U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 13 June 2006

CASE NO. 2004-LHC-0148

OWCP NO. 14-139803

In the Matter of:

ROBERT KOHLBECK,
Claimant,

vs.

BRISTOL ENVIRONMENTAL & ENGINEERING SERVICES CORP. and
ZURICH-AMERICAN INSURANCE CO.,
Employer and Carrier.

Appearances:

Christopher Kuebler, Esq.
O'Bryan, Baun, Cohen & Kuebler
For Claimant

Michael W. Thomas, Esq.
Laughlin, Falbo, Levy & Moresi
For Employer/Carrier

Patricia Drummond, Esq.
Office of the Solicitor
For the Department of Labor

Before: ALEXANDER KARST
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

Robert Kohlbeck seeks compensation and medical benefits under the Longshore and Harbor Workers' Compensation Act, *as amended*, 33 U.S.C. § 901 *et seq.* ("the Act"), for injuries arising out of a fall onto his left knee which occurred on April 5, 2002, while he worked as a laborer for Bristol Environmental & Engineering Services Corporation ("Employer").

The parties agree that Claimant sustained an injury at work which resulted in an impairment of his left knee. The primary issues in dispute relate to the nature and extent of the resulting disability. Claimant alleges that he is entitled to a scheduled award for his knee injury, as well as an unscheduled award for a medical condition known as complex regional pain syndrome, which he alleges he developed as a result of the knee injury. He further alleges that he is permanently and totally disabled. Employer, who challenges the diagnosis of complex regional pain syndrome, seeks a finding that any award for permanent disability is limited to the schedule for left knee impairment. Employer further asserts that Claimant is not totally disabled because he is capable of performing alternative employment.

FACTUAL BACKGROUND

Claimant, born in 1964, was 40 years old at the time of trial. He has lived in Homer, Alaska for 26 years. He has worked primarily in the maritime industry since age 15, and has obtained marine licenses including a 100-ton master's license, able-bodied seaman unlimited, inspected master of towing, and a license to transport hazardous materials. Tr. at 34-35. Claimant also has radar, fire-fighting and first-aid training.

Prior to sustaining the injury which is the subject of this claim, Claimant was treated for numerous medical conditions. His medical history includes a crushed left wrist in 1982 or 1983, back pain due to possible compression fracture in 1987, hospitalization for acute abdominal pain in 1991, bilateral carpal tunnel syndrome which was surgically treated in 1992, recurrent back pain in 1993, extensor tendon repair in 1993, right shoulder pain and numbness in the right upper extremity in 1994, left knee injury in 1995, and chronic myofascial pain in 1998. As early as 1989, there are indications of a "very long and involved history with chronic alcohol intoxication." EX 16 at 408. In April 1993, Claimant's young daughter was killed in a tragic accident in Anchorage. EX 16 at 395. He reported to the emergency room shortly thereafter, where the impression was acute severe grief. EX 16 at 394. On April 14, 1993, Claimant was hospitalized after mixing vodka with Valium and Xanex. His family physician, Dr. William Bell, feared that Claimant "is clearly reaching the end of his particular coping abilities. Left to his own devices he is mixing chemicals in a very dangerous mechanism." EX 16 at 392.

In July 1995, Claimant was hospitalized for eighteen days for pancreatitis. Dr. Paul Eneboe recounted a "long history of known recurrent pancreatitis, multiple admissions to the Emergency Room and hospital for abdominal pain, pancreatitis and long history of alcohol abuse plus analgesic and poly drug abuse." EX 16 at 373. It was further noted that Claimant "has a long history of chronic pain and analgesic abuse. He tends to use a lot of medications." EX 16 at 374. The discharge diagnoses were: (1) acute phlegmonous pancreatitis; (2) acute chronic alcohol abuse; and (3) chronic pain. EX 16 at 374. Claimant was again hospitalized in October 1995 with recurrent pancreatitis. He denied alcohol use, but admitted he "had been drinking a lot of Nyquil," which contains thirty to forty-percent alcohol. EX 16 at 355. Claimant's pancreatitis ultimately required pancreatic resection and partial jejunectomy. He underwent alcohol detoxification in late 1995. Claimant's use of narcotic pain medications is noted in his medical records on several dates in 1995. In November 1995, Dr. Eneboe reported that Claimant has "a difficult problem with pain medications and [he] is always very difficult to assess because of his pain medication dependence." EX 16 at 346. Claimant was treated for migraine headaches in

1996. Headaches and chronic pain related to pancreatitis continued to be problems in 1997 and 1998, and around that time, Claimant began taking Methadone for pain. In February 2002, his pain medications included Methadone, Percocet and Valium. EX 21.

In March 2002, Employer hired Claimant as a boat captain to pilot the vessel *Bristol Endeavor* from Seattle, Washington to Homer, Alaska. Prior to departure, Claimant worked for Employer as a laborer while the vessel was being refurbished in Seattle. He was injured on April 5, 2002, when he tripped over a vise and fell onto his bent left knee. EX 36 at 46-49. He sought medical attention at the emergency room at University of Washington Medical Center, where he was diagnosed with left knee contusion and released. EX 17 at 469-70. He returned to work on or about April 8, but continued to experience knee pain. EX 36 at 52. He visited the emergency room on April 30 and was diagnosed with recurrent knee pain. EX 17 at 464-65.

On May 11, 2002, the *Bristol Endeavor* left Seattle with Claimant acting as master. The vessel arrived in Homer, Alaska on or about June 5, 2002, and Claimant's employment was terminated. CX 112. He returned home to Homer, Alaska, and reported pain and swelling in the left knee to Dr. Bell. Dr. Bell referred Claimant to Dr. Daniel McCallum, an orthopedic surgeon.

On June 17, 2002, Dr. McCallum examined Claimant and reviewed radiographs of his left knee. Findings on physical examination included swelling and diminished sensation over the front of the knee, limited range of motion, and tenderness over the quadriceps tendon and prepatellar bursa. CX 81 at 13. Dr. McCallum formed three diagnoses, which he felt were confirmed by MRI: (1) quadriceps tendinosis; (2) prepatellar bursitis; and (3) saphenous nerve neuritis. CX 81 at 14. Dr. McCallum felt the quadriceps tendinosis was not severe enough to warrant surgery. On June 28, 2002, Dr. McCallum interpreted the MRI as also revealing a probable medial meniscal tear. CX 17 at 42. He reported his suspicion that Claimant has "a more proximal pain syndrome." CX 17 at 43. He said, "This is a very, very confusing picture. He has pain that is well out of proportion to what I would expect for the diagnoses given." *Id*. Dr. McCallum testified that he was less concerned about the meniscus tear than the other diagnoses, but he offered to repair the meniscus to eliminate it as a possible source of pain. CX 81 at 17. On July 2, 2002, Claimant saw Dr. Michael Taylor at the Pain Management Clinic in Anchorage. Dr. Taylor performed a saphenous nerve block and refilled Claimant's pain medications, including Methadone, Actiq, Vicodan and Valium. EX 21 at 599.

On July 16, 2002, Dr. McCallum performed a partial medial meniscectomy. Arthroscopic findings included a softening of cartilage around the kneecap and areas of worn cartilage in the femoral condyle, above the meniscus tear. CX 81 at 33. Claimant was referred for physical therapy. On July 26, the physical therapist reported that Claimant is "able to fire all muscles involved," working hard, and progressing according to plan. CX 17 at 41; EX 19 at 534. On August 7, Claimant reported to his physical therapist that he had gone fishing with minimal knee discomfort. The therapist noted minimal swelling in the knee, and that Claimant was doing "excellent" in terms of range of motion and strength. EX 19 at 535. However, on August 28, Claimant returned to Dr. McCallum with left leg pain. EX 18 at 509.

On September 11, 2002, Dr. McCallum again opined that Claimant's pain is "well out of proportion to what the diagnosis should give him." EX 18 at 504. On December 16, 2002, Dr. McCallum reported that Claimant has "titrated down to an all time low of pain medicine." He noted that Claimant is still having anterior knee pain and pain in the back of his left thigh and buttocks, with left leg numbness and weakness. CX 17 at 34. On December 24, 2002, an MRI of Claimant's low back was interpreted as normal except for slight wedging of the T11, T12, and L1 vertebrae. There was felt to be no focal disk protrusion or spinal canal stenosis. CX 14 at 29.

Dr. McCallum testified that after the partial meniscectomy, "we were entertaining" a diagnosis of "chronic regional pain syndrome" [*sic*]. CX 81 at 18. He testified that this condition was formerly known as reflex sympathetic dystrophy. CX 81 at 36. The record shows that due to developments in the medical community's understanding of this condition, reflex sympathetic dystrophy ("RSD") is now more commonly referred to as complex regional pain syndrome ("CRPS"). The names RSD and CRPS are frequently used interchangeably. *See* EX 38 at 8, EX 39 at 24. To avoid confusing the two syndromes, i.e. "complex regional pain syndrome" and a distinct condition known as "chronic pain syndrome," discussed below, RSD will be used rather than CRPS in referring to the condition from which Claimant alleges he suffers. It appears, and I find, that Dr. McCallum misstated the name of "complex regional pain syndrome," substituting the word "chronic" for the word "complex" in his deposition testimony.

On January 14, 2003, Dr. Bell referred Claimant to C.W. Jasper for treatment of chronic pain.[1] C.W. Jasper is not a medical doctor. He holds the degree "Doctor of Naturopathic Medicine" from the American College of Naturopathic Medicine, and is licensed to practice naturopathic medicine in Alaska. He also holds a Master of Science in nursing from the University of Alaska, and is a licensed advanced nurse practitioner. CX 84 at 5-6. Dr. Jasper examined Claimant and ordered a "nerve study" of his low back. CX 84 at 10. He testified that he diagnosed Claimant with RSD and prescribed narcotic pain medication including Duragesic, Methadone, and Actiq. CX 84 at 13.

On January 22, 2003, Dr. McCallum reported that Claimant's knee is less tender. CX 17 at 33. On February 14, 2003, he referred Claimant to Dr. John Shannon for "what I believe are electrodiagnostic studies to the lumbar spine," which had been requested by Dr. Jasper. CX 26; CX 17 at 33; CX 82 at 8. On February 26, 2003, Dr. McCallum opined that Claimant's left knee conditions "could improve with time and rehab," but he said he would "sign off on [Claimant] orthopedically as I think he needs someone else to help manage his other pain issues and medical problems." CX 17 at 32. Dr. McCallum further opined, "I think at this point orthopedically he will not be able to return to the prior occupation he was at." *Id.* He recommended that Claimant undergo a functional capacity evaluation.

On March 11, 2003, Claimant was seen by Dr. Shannon. Dr. Shannon is a chiropractor specializing in electrodiagnostic medicine. He obtained a degree from New York Chiropractic College in 1984, and is licensed to practice chiropractic medicine in Alaska, New York and Colorado. CX 83 at 3-4. He had private tutoring for somatosensory evoked potentials through Gary March, head technician at Albany Medical Center, Department of Neurology, and professional training with Dr. Reynaldo Lazaro, associate professor at Albany Medical College.

[1] C.W. Jasper apparently took over Claimant's pain management after Dr. Taylor left Alaska.

Dr. Shannon took a post-graduate program for EMG and nerve conduction studies at Neumann College in Pennsylvania, which consisted of about 300 hours over eleven months. CX 83 at 5-6. He is a Diplomate of the National Academy of Thermography.

During his visit with Dr. Shannon, Claimant complained of pain in the left knee, low back, anterior thigh and medial leg, occasional sharp pain down the posterior thigh and leg, and a burning sensation in the left lower extremity. He reported that even slight friction over the area causes pain. CX 9 at 16. Dr. Shannon reported that a physical examination revealed medial knee tenderness and decreased feeling following the saphenous nerve from the knee to the distal aspect of the leg and ankle. CX 83 at 41-15. Measurements of the limbs two inches from the knee were 48½ centimeters on left and 47½ centimeters on right; calves were 42½ centimeters on left, 43 centimeters on right; and patellar region measurements were 45½ centimeters on left, 43 centimeters on right. Dr. Shannon felt these were "abnormal measurements around the knee because of swelling which was visualized as well," but were otherwise normal. Dr. Shannon also performed an EMG and nerve conduction studies. He interpreted the results of both studies as essentially normal.[2] CX 83 at 12-13. Because the studies did not explain Claimant's symptoms, Dr. Shannon performed a somatosensory evoked potential of the left saphenous nerve. He interpreted the results for the right side as within acceptable standards for Claimant's height. CX 9 at 19. On the left, Dr. Shannon found a latency of 3.8 milliseconds which he interpreted as abnormal for saphenous nerve block. CX 83 at 16. He opined that Claimant sustained blunt trauma to the knee which resulted in left saphenous nerve injury. He opined that "constant irritation" of the nerve caused Claimant to develop RSD. CX 83 at 18. He recommended a lumbar sympathetic block. CX 9 at 20.

Claimant was referred by Dr. Jasper to Dr. Leon Chandler for a lumbar sympathetic block. CX 123; CX 84 at 12-13. Dr. Chandler has a medical degree from Indiana University, is not board-certified in any specialty, but designates himself an anesthesiologist practicing pain management. CX 85 at 5. He examined Claimant on April 16, 2003, and recorded Claimant's reports that he has hair loss, abnormal sweating, and temperature differences between the legs. CX 123. On examination, Dr. Chandler reported that the left leg felt cooler than the right to the back of his hand. He also reported that the temperature just above the knee was 88 degrees in both limbs according to temperature strips applied to the skin, which he felt are more accurate. CX 123. The sympathetic block he performed reportedly provided Claimant little relief. In a letter to Dr. Jasper written the day of the exam, Dr. Chandler agreed that Claimant has "complex regional pain in the left leg, initiated with a traumatic episode with arthroscopic evaluation. It appears to me that he has early [RSD] and should respond to sympathetic blocks." CX 124.

On May 5, 2003, Claimant saw Dr. Shannon for a permanent impairment rating. Dr. Shannon testified that he is certified by the American Academy of Independent Medical Examiners to perform impairment ratings, and has performed roughly 100 ratings. CX 83 at 23. Dr. Shannon testified that he rated five distinct aspects of Claimant's condition under the fifth edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* ("the AMA *Guides*" or "the *Guides*"). For saphenous nerve injury, Dr. Shannon

[2] Dr. Shannon testified that abnormal findings included slight delays on right and left through the tarsal tunnel regions in Claimant's feet, which are not contributing to the injury that is the subject of this claim. CX 83 at 11-12.

estimated the amount of nerve damage and assigned two-percent whole person impairment. Secondly, he gave Claimant fifteen-percent whole person impairment for RSD. Thirdly, Dr. Shannon assigned one-percent whole person impairment for the partial meniscectomy. Fourthly, Dr. Shannon gave Claimant four-percent whole person impairment for loss of range of motion in the knee, which he felt was difficult to gauge because Claimant complained of pain. Finally, he added two-percent whole person impairment for pain. CX 83 at 24-27. Dr. Shannon aggregated the impairments and concluded that overall Claimant has a 23-percent whole person impairment. CX 83 at 27. He attributed each of the rated conditions to the work-related fall. CX 83 at 29.

On October 6, 2003, Claimant underwent an orthopedic examination at Employer's request by Dr. Bradley Billington, a board-certified orthopedic surgeon.[3] He diagnosed the following conditions which he thought resulted, more probably than not, from Claimant's fall on April 5, 2002: (1) left knee contusion; (2) quadriceps strain; (3) prepatellar bursitis; and (4) irritation of the left saphenous nerve as a result of the contusion.[4] Dr. Billington opined that the partial meniscectomy was necessitated by Claimant's fall. EX 39 at 13-14. He opined that Claimant has two-percent impairment of function of the left lower extremity as a result of the meniscectomy. EX 12 at 53. He testified that under the *AMA guides*, he may find additional impairment based on parameters other than the meniscectomy. In this case, however, he concluded that there is no basis for additional impairment.

Dr. Billington testified that he is trained to recognize and diagnose RSD and that based on his physical examination, he does not believe Claimant has RSD. EX 39 at 23-24. Although he reported a "palpable" degree of coolness of the left leg and foot, Dr. Billington testified that he would not diagnose RSD based on a single objective finding. EX 39 at 23. Specifically, he noted no hair pattern differences in either limb and no trophic nail changes. EX 12 at 49. Dr. Billington felt Claimant should be examined by a physiatrist or neurologist to confirm the presence or absence of RSD. EX 12 at 52. Dr. Billington opined that Claimant has "a chronic pain syndrome," a condition which pre-existed his April 5, 2002 injury at work, and which is entirely distinct from RSD. He explained that "chronic pain syndrome" is a term used to define a problem experienced by a patient who is manifesting pain without a readily identifiable underlying anatomical or physiological cause. EX 39 at 73. Dr. Billington further opined that Claimant has a "profound disability syndrome, and that in an overall sense is probably much more important than any objective loss of function of the knee." EX 12 at 53. Dr. Billington testified that on the basis of how disabled Claimant thinks he is and considering his use of "high levels of Class 2 scheduled narcotics, I am quite pessimistic that he will be rehabilitated to a functional level." EX 39 at 97.

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[3] Dr. Billington received his board-certification and opened a private practice in 1976. Prior to 1976, he spent four years as a physician in the military. Since March 2003, he performs medical evaluations for Concentra Medical Evaluations, and is its medical director for northwestern United States.

[4] Dr. Billington further testified that based on review of the medical records, he identified several conditions which he felt were neither related to nor aggravated by Claimant's fall at work, including: (1) a chronic pain syndrome; (2) left knee injury in April 1995; (3) pre-existing bilateral carpal tunnel syndrome; (4) pre-existing chronic shoulder pain; (5) pre-existing, mild compression fractures of T11 and T12, and possibly L1; and (6) chronic alcoholism resulting in chronic severe pancreatitis. EX 39 at l4-15.

Beginning on November 4, 2003, Claimant underwent a two-day functional capacity evaluation ("FCE"), administered by Bernadette Arsenault. CX 77. Significant abilities which were identified included "very strong upper body strength, good hand grip and upper extremity coordination. He did well with elevated work while standing, waist to overhead lift, right hand carry, and static and dynamic push/pull." CX 77 at 238. Deficits included: (1) inability to properly stabilize trunk musculature during squats, floor to waist lifts, left hand carry, and forward bending; (2) limited left knee range of motion which makes squatting and crouching difficult; and (3) as Claimant's symptoms of discomfort increase, the ability to bear weight on the left extremity decreases which affects walking, balance, squatting, horizontal lifting, front carrying, and static standing and sitting. CX 77 at 238. It was noted that objective signs of increased heart rate on day two of the FCE corroborated Claimant's statements of discomfort.

As suggested by Dr. Billington, Claimant was seen on March 17, 2004 at Employer's request by Dr. Jacquelyn Weiss, board-certified neurologist, to determine whether he has RSD.[5] Dr. Weiss reviewed Claimant's medical records, interviewed him, and performed a physical exam. On examining the lower left limb, she noted hair that was shorter on left than right and "bristly." She found no swelling and no differences in temperature or color between limbs. EX 38 at 10. She noted normal capillary refill and an absence of abnormalities in the skin or toenails in either leg. On motor exam, Dr. Weiss observed no atrophy and concluded that Claimant "is really not limping or favoring that limb on a day-to-day basis." EX 38 at 12. She concluded that her physical exam revealed no objective findings to support a diagnosis of RSD. EX 13 at 79.

On April 3, 2006, Claimant requested leave to supplement the record for the reason that his alleged RSD has "progressed and is spreading." Employer opposes Claimant's motion.

DISCUSSION

The findings and conclusions which follow are based on a review of the record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent precedent. The parties agree that: (1) Claimant sustained an injury on April 5, 2002 that resulted in impairment of his left knee; (2) Claimant's knee injury arose out of and in the course of employment; (3) Claimant's injury occurred at a maritime situs while he was engaged in a maritime activity; and (4) the claim for benefits was timely. The following issues are in dispute: (1) whether Claimant's knee injury caused him to develop RSD; (2) the nature and extent of disability; (3) average weekly wage; (4) Employer's entitlement to section 8(f) relief; (5) Claimant's entitlement to medical expenses; (6) Employer's entitlement to a section 3(e) credit; and (7) whether Claimant may supplement the record with additional evidence.

1. Compensable Injury

A worker's injury is not compensable unless the injury arose out of and in the course of employment. *See* 33 U.S.C. §902(2). In making this showing, a claimant is aided by section

[5] Dr. Weiss has a Ph.D. in theoretical physics from Harvard University (1975) and a medical degree from University of Miami School of Medicine (1979). She is a Diplomate of the American Board of Psychiatry and Neurology, and is board-certified in clinical neurophysiology.

20(a), which provides that in proceedings to enforce a claim under the Act, "it shall be presumed, in the absence of substantial evidence to the contrary . . . that the claim comes within the provisions of the Act." 33 U.S.C. §920(a). To invoke this presumption, a claimant must establish that he sustained physical harm or pain, and that working conditions existed or an accident occurred that could have caused the harm. *Kelaita v. Triple A Machine Shop*, 13 BRBS 326 (1981). Once this prima facie showing is made, section 20(a) creates a presumption that the injury arose out of employment. To rebut the presumption, an employer must present specific medical evidence severing the connection between the physical harm and working conditions. *Brown v. Pacific Dry Dock*, 22 BRBS 284 (1989). If the presumption is rebutted, the administrative law judge must weigh the evidence and resolve the issue based on the record as a whole. *Hislop v. Marine Terminals Corp.,* 14 BRBS 927 (1982). The ultimate burden of proof rests on the claimant. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994).

a. *Left Knee Injury*

The parties agree that on April 5, 2002, Claimant injured his left knee when he tripped and fell on bent knee in the course and scope of his employment. Accordingly, harm and an accident which could have caused the harm have been shown to exist. The presumption that Claimant's knee injury is related to his employment has been invoked, and no evidence has been offered to rebut the presumption. However, the disabling effects of that injury are in issue.

b. *RSD (Reflex Sympathetic Dystrophy)*

Claimant alleges that he developed RSD as a result of the work-related left knee injury. In support of this contention, Claimant testified that his left knee pain was not alleviated by the meniscectomy performed by Dr. McCallum, and that after surgery he developed severe, constant pain in his left leg that radiates to his left buttock and lower back. In February 2003, Dr. McCallum felt that no further orthopedic treatment of the left knee was warranted, but Claimant required assistance with pain management. CX 17 at 32. I find that Claimant has presented enough evidence to support his contention that he suffered from continuing pain and that his work-related accident could have caused the harm. Section 20(a) of the Act thus shifts to Employer the burden of rebutting the presumption invoked by Claimant's prima facie case.

To rebut the presumption, Employer relies on the opinions of its two medical experts, Dr. Billington and Dr. Weiss, to challenge the diagnosis of RSD. Dr. Billington testified that his examination of Claimant revealed only one finding, coolness of the left limb, which would support a diagnosis of RSD, but he said he would not diagnose RSD based on one objective finding. He deferred to a neurologist or physiatrist to confirm the absence of RSD. Dr. Weiss, a neurologist, testified that the objective findings necessary for a diagnosis of RSD were not present when she examined Claimant. She further opined that Dr. Shannon's diagnosis is invalid because it was made in the absence of objective medical signs. I find that this testimony is sufficient to rebut the presumption. *See Devine Atlantic Container Lines,* G.I.E., 23 BRBS 280 (1990). Accordingly, it is necessary to consider the evidence as whole to determine whether Claimant has shown a connection between his alleged RSD and the work-related accident.

Claimant contends that the opinions and testimony of Dr. Shannon and Dr. Jasper support a finding that he has RSD.[6] Dr. Shannon testified that he diagnosed RSD based on Claimant's history, physical exam, and clinical findings. CX 83 at 20. He observed that Claimant's medical records contain reports of a "high level of pain" which was not alleviated by medical procedures or pain medications. Dr. Shannon said, "Add to this the burning sensation, swelling and extreme hypersensitivity at or around the site of injury, and this patient seems to fall squarely within complex regional pain syndrome, type I [RSD]." CX 9 at 18. Dr. Jasper testified that he concluded based on a reasonable degree of probability, that Claimant has RSD. CX 84 at 12.

For the reasons explained below, I am not persuaded by Dr. Shannon's opinion that Claimant has RSD. Under the regulations implementing the Act, the term "physician" includes a chiropractor, but "only to the extent that [his] reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation shown by X-ray or clinical findings." 29 C.F.R. §702.404. The statute governing chiropractic practice in Alaska defines "chiropractic" in part as "the clinical science of human health and disease that focuses on the detection, correction, and prevention of the subluxation complex." Alaska Statutes §08.20.900(3) (2004). The Alaska statute defines "subluxation complex" as "a biomechanical or other disrelation or a skeletal structural disrelationship, misalignment or dysfunction in a part of the body resulting in aberrant nerve transmission and expression." *Id.* at §08.20.900(10) (2004). "Subluxation" is defined in *Dorland's Medical Dictionary*, 26th edition, as "an incomplete or partial dislocation." Here, Dr. Shannon purports to diagnose a complex neurological condition which each of the medical providers of record has agreed is elusive, not well understood, and difficult to diagnose. There is no evidence or allegation that RSD is caused by or is related to a dislocation of the spine or skeletal structure. Accordingly, I find that Dr. Shannon lacks the essential credentials to diagnose or offer expert testimony about RSD, and that diagnosing RSD exceeds the bounds of his Alaska professional license. As a result, I give no weight to Dr. Shannon's opinion on this issue.

Dr. Jasper's testimony regarding RSD is rejected for similar reasons. Dr. Jasper is a naturopath. The Alaska statute which governs the practice of naturopathy defines it as "the use of hydrotherapy, dietetics, electrotherapy, sanitation, suggestion, mechanical and manual manipulation for the stimulation of physiological and psychological action to establish a normal condition of mind and body." Alaska Statutes §08.45.200(3) (2004). The Alaska statute prohibits a naturopath from prescribing prescription drugs or controlled substances, engaging in surgery, or using the word "physician" in the person's title. Alaska Statutes §08.45.050 (2004). Although Dr. Jasper is also a nurse practitioner, neither a naturopath nor a nurse practitioner is

[6] Claimant contends that Employer arranged to have Dr. McCallum refer Claimant to Dr. Shannon. Therefore, according to Claimant, Dr. Shannon is Employer's "agent" and Employer is "bound" by Dr. Shannon's conclusion that Claimant has RSD. This contention is without merit. The record shows that Dr. McCallum referred Claimant to Dr. Shannon by referral form dated February 14, 2003, for "EDS" with "emphasis on lumbar plexus and root level." CX 26. The record contains three letters between Dr. Shannon and Corvel Corporation, which requested services for Claimant on behalf of Employer's insurer, Zurich Services. CX 43, 44, 12. The first is a memorandum dated March 11, 2003. CX 43. The second letter, dated April 16, 2003, requests that Dr. Shannon perform an impairment rating. CX 44. Third, there is a Physician's Report signed by Dr. Shannon, dated May 5, 2003. CX 12. These documents do not show that Employer asked Dr. McCallum to refer Claimant to Dr. Shannon, as each is dated at least one month after Dr. McCallum's referral. Moreover, because I give no weight to the testimony of Dr. Shannon on the issue of whether Claimant has RSD, I find Claimant's "agency" argument to be irrelevant.

included in the definition of the term "physician" for purposes of the Act. *See* 29 C.F.R. §702.404. Accordingly, I find that Dr. Jasper lacks the essential credentials to diagnose RSD or to offer expert testimony about it, and I give no weight to his opinion on this point.

Claimant also argues that an RSD diagnosis is supported by the testimony of Dr. McCallum, the treating physician for his knee conditions. Dr. McCallum did testify that he feels Claimant suffers from RSD. CX 81 at 36. His opinion is based on the facts that the arthroscopic surgery he performed on Claimant's knee revealed no significant findings beyond a small meniscus tear; that Claimant did not obtain relief from pain after the tear was repaired; and that after surgery, Claimant began to experience additional painful symptoms in the left limb. Dr. McCallum testified that it is "entirely possible" that the knee injury caused RSD. CX 81 at 38. He testified that he believes that RSD is the source of the majority of Claimant's symptoms.

Claimant further asserts that a diagnosis of RSD is supported by Dr. Chandler and Dr. Paul Raymond of Kachemak Bay Medical Center in Homer. Dr. Chandler, having examined Claimant on April 16, 2003, wrote to Dr. Jasper that he agreed that Claimant has "complex regional pain in the left leg, initiated with a traumatic episode with arthroscopic evaluation. It appears to me that he has early [RSD] . . . ." CX 124. At deposition, however, Dr. Chandler testified that Claimant came to him with a diagnosis of RSD, which he assumed was made by another physician. CX 85 at 8. In a medical record dated sometime in 2003, Dr. Raymond reported that Claimant "is here to obtain a referral to the Advanced Pain Center of Alaska. He suffers from chronic abdominal and low back pain. He carries a diagnosis of chronic reflex sympathetic dystrophy." CX 13 at 28. Claimant was given Methadone and referred to the Advanced Pain Center. *Id*. In a record dated April 18, 2003, a medical provider with initials "PDR" indicated that Claimant "presents at this time for followup of his chronic pain syndrome and chronic reflux sympathetic dystrophy" [*sic*]. The assessments were "chronic regional pain syndrome" [*sic*] and "reflux sympathetic dystrophy" [*sic*]. *Id*. Claimant was given a referral to mental health for chronic pain, depression and anxiety. *Id*.

Dr. Weiss testified for Employer that according to the AMA *Guides*, eight or more objective diagnostic criteria should be present in order to make a probable diagnosis of RSD. Dr. Weiss concluded that Claimant's physical exam did not reveal the types of objective findings which would indicate RSD. First, there may be vasomotor changes, including changes in skin color (mottled or cyanotic), cool skin temperature, and edema. Dr. Weiss testified that neither she nor any other medical provider of record had documented changes in the skin color of the left extremity. She found no edema or temperature difference in the two limbs, but acknowledged that Dr. Billington documented a cool left limb. EX 38 at 18. A second set of signs of RSD may be sudomotor changes, exhibited by skin which is overly dry or moist. Dr. Weiss noted there were no findings that Claimant's skin was overly dry or moist during her exam or in the medical records. A third category of signs of RSD may be trophic changes, including smooth, non-elastic skin texture, soft tissue atrophy, joint stiffness and decreased passive motion, nail changes (blemished, curved, talon-like), and hair changes (fall out, longer, finer). Dr. Weiss found that Claimant's skin and nails were normal. Although Claimant reported hair loss on his left leg, Dr. Weiss felt he had shaved the limb because "when hair is shaved, it comes in thick and bristly. When it's not shaved and gets pulled out or falls out on its own, it comes in fine. His is very bristly." EX 38 at 10. She felt he did not meet this criterion. Next, Dr. Weiss noted possible joint stiffness in Claimant's knee, but said she would defer to Dr. Billington on the knee

condition. Finally, there may be radiographic signs of RSD including trophic bone changes, osteoporosis, and specific bone scan findings. EX 14. In this regard, Dr. Weiss noted the absence of changes such as atrophy on Claimant's x-rays, which she felt would be expected if he were developing RSD. EX 38 at 20. She concluded that on an objective basis, she could not identify any neurologic condition caused or aggravated by the April 2002 knee injury. EX 13 at 80. She felt that on a neurologic basis, Claimant requires no additional treatment and has no work restrictions. She deferred to Dr. Billington for treatment recommendations and restrictions for the knee. EX 13 at 81.

Dr. Billington also testified for Employer that he does not believe that Claimant has RSD. Dr. Billington explained that RSD has various phases and symptoms. Phase one includes increased blood flow, swelling, skin which is pink and warm, skin surface sensitivity, and decreased joint mobility. EX 39 at 76-77. The increased blood flow may result in overgrowth of hair or toenails. If untreated, phase two involves vasoconstriction, resulting in skin which is cool, purplish or cyanotic, hardening of tissues, and contractures of the involved joints. EX 39 at 77. In phase three, there may be bone loss and profound atrophy. *Id.* He testified that his examination of Claimant revealed none of the findings which he had described as consistent with RSD, with the exception of a "palpable degree of coolness of the left leg and left foot." EX 39 at 23. He testified that he would not diagnose RSD on the basis of that single objective finding.

Dr. Billington opined that Claimant has "a chronic pain syndrome," a condition entirely distinct from RSD (which, confusingly, is often mistakenly referred to in this file as "chronic regional pain syndrome"). He testified that chronic pain syndrome would not have the types of findings that are associated with RSD. EX 39 at 77. He explained that chronic pain syndrome is a term used when a patient is manifesting pain without an identifiable underlying physiological cause. EX 39 at 73. Dr. Billington further explained that individuals who are defined as having chronic pain syndrome typically have undergone evaluation by a variety of practitioners with no source for the patient's pain having been identified, and the individual has not responded to diagnosis and treatment by "normal methodologies." EX 39 at 75. He testified that in these situations, the patient is given medication rather than pursuing further investigation, so that an individual with chronic pain is typically taking narcotics on an ongoing basis. EX 39 at 73.

It is well-settled that the Act must be construed liberally in favor of the claimant. *Voris v. Eikel*, 346 U.S. 328, 333 (1953). However, the United States Supreme Court has held that a claimant bears the ultimate burden of persuasion by a preponderance of the evidence. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251 (1994), *aff'g.* 990 F.2d 730 (3rd Cir. 1993). *See also*, 5 U.S.C. §556(d). In the Ninth Circuit, where this case arose, a claimant's treating physician's opinion is entitled to "special weight" in considering medical evidence. *Amos v. Director, OWCP*, 153 F.3d 1051 (9th Cir. 1998).

I have weighed the testimony of Dr. McCallum in light of the holding in *Amos*. Dr. McCallum testified that he feels Claimant suffers from RSD based on his unexplained ongoing pain following surgical repair of the medial meniscus. CX 81 at 36. Indeed, Dr. McCallum's treatment records following surgery reflect that he felt that Claimant had pain beyond what the diagnosed knee conditions should have given him. He also reported his suspicion that Claimant has "a more proximal pain syndrome of sorts." CX 17 at 43.

Even though I have given special weight to the testimony of Dr. McCallum, I find that the evidence as a whole does not support a finding that Claimant developed RSD as a result of his fall on April 5, 2002. First, I find the persuasiveness of Dr. McCallum's opinion that Claimant has RSD, which is based largely on his observations of Claimant's pain, is undermined by his testimony that a patient with RSD would present not just with pain, but also with a "set of unique symptoms." CX 81 at 38. Dr. McCallum did not testify that Claimant has the "unique symptoms" which characterize RSD, nor did he identify what those symptoms would be. Presumably, they would be the symptoms listed by Drs. Weiss and Billington. Dr. McCallum's treatment records reveal no findings or reports of any of the signs of RSD beyond Claimant's complaints of pain, nor do they indicate that Dr. McCallum suspected that Claimant was developing RSD, as opposed to "a more proximal pain syndrome of sorts." CX 17 at 43. Secondly, Dr. McCallum appears to have confused or blurred the distinction between RSD, which presents with unexplained pain together with other objective signs, and "chronic pain syndrome," which is simply pain for which physicians can find no physiological explanation. Throughout his entire deposition, Dr. McCallum mistakenly referred to Claimant's condition as "*chronic* regional pain syndrome," instead of "*complex* regional pain syndrome," which was formerly known as RSD. *See, e.g.*, CX 81 at 18, 20, 22, 24, 28, 36 and 38. Such confusion might be understandable in a lay person speaking of medical conditions with similar names, but it is not so easily dismissed in the testimony of an expert on the core issue of the case. Thirdly, Dr. McCallum repeatedly emphasized at deposition that he did not treat Claimant for RSD, but referred him to pain management in February 2003 for treatment of ongoing pain. See CX 81 at 18, 21-22, 23-24, and 28. In light of the foregoing, I find that Dr. McCallum's testimony that he believes Claimant has RSD is not very persuasive. Moreover, I find that there is insufficient evidence to establish that the opinions of either Dr. Chandler or Dr. Raymond support a diagnosis of RSD, as neither of these physicians appears to have independently arrived at that diagnosis. They appear to have simply relied on and recorded a presumed diagnosis previously formed by some other medical provider.

On the other hand, I find the opinion of Dr. Billington most persuasive. I find that unlike Dr. McCallum, Dr. Billington presented an in-depth explanation of the medical signs, or the absence thereof, which support his conclusion that Claimant does not have RSD. In addition, I find that Dr. Billington gave thorough consideration to Claimant's medical records and the opinions of other medical providers, and that his conclusion that Claimant lacks sufficient objective signs of RSD is consistent with the record as a whole. Finally, I find that the opinion of Dr. Billington is consistent with and supported by the credible opinion of Dr. Weiss. Although the testimony of Dr. Weiss struck me as being overly partial to the Employer, and despite the fact that her testimony suggested a view of pain so stoical as to rule out the genuineness of most pain complaints, I nevertheless recognize that she is a neurologist who has sterling credentials which clearly qualify her to render an opinion about RSD. Although somewhat reluctantly, I find that Dr. Weiss's detailed testimony about the lack of signs of RSD is persuasive and lends support for the conclusion of Dr. Billington that Claimant has not demonstrated that he has RSD.

The record shows that Claimant, though only 40 years old, has had a great deal of medical treatment, suffered a devastating personal tragedy, has had trouble with alcohol abuse, and reports disabling pain which most of the credible medical providers of record find to be far in excess of what could be expected from the relatively minor knee injury and the ensuing partial

meniscectomy. But whatever its cause, I am persuaded by Dr. Billington's conclusion that Claimant's medically unexplainable chronic pain, i.e. "chronic pain syndrome" in medical parlance, pre-existed his knee injury of April 5, 2002. Dr. Weiss also opined that Claimant has chronic pain syndrome which pre-existed his April 2002 injury, and that "psychosocial factors and addiction/substance issues are playing a significant role in his presentation." EX 13 at 80. The conclusions of these expert physicians have ample support in the Claimant's medical records which they analyzed. As early as 1995, the records reflect Claimant's "long history of chronic pain and analgesic abuse." EX 16 at 374. Claimant's complaints of pain are elaborately documented in the medical records long before he sustained his work-related knee injury. The knee injury simply appears to provide a new focus for the pain.

In sum, I find that Claimant has established that his left knee condition is related to his April 2002 accident at work, but that he has failed to establish that he developed RSD as a result of the work injury or that any other pain-related impairment was caused or aggravated by the fall onto his knee which occurred in the course and scope of his employment. Having established a left knee injury, the burden now rests on Claimant to prove the nature and extent of his disability. *Trask v. Lockheed Shipbuilding Construction Co.*, 17 BRBS 56 (1985).

2. Nature and Extent of Disability

a. *Date of Maximum Medical Improvement*

The nature of a disability is distinguished according to its duration—permanent or temporary. *See* 33 U.S.C. §908. A disability becomes permanent when the claimant reaches maximum medical improvement. *Phillips v. Marine Concrete Structures, Inc.*, 21 BRBS 233, 235 (1988). Maximum medical improvement is reached once it is determined that the employee has received the maximum benefit medical treatment such that his condition will not improve. Whether an injured worker has achieved maximum medical improvement is primarily a question of fact based upon the medical evidence. *Williams v. General Dynamics Corp*., 10 BRBS 915 (1979). Employer contends that Claimant's knee reached maximum medical improvement on February 26, 2003 when Dr. McCallum reported, "I think that the quadriceps tendinosus, patellofemoral chondrosis and even the saphenous nerve neuritis could improve with time and rehab. I think overall [Claimant's] other medical conditions have greater weight at this point. We are going to sign off on him orthopedically as I think he needs someone else to help manage his other pain issues and medical problems." CX 17 at 32. Claimant does not dispute Employer's contention that Dr. McCallum thereby released him from orthopedic care.

I conclude that Claimant reached maximum medical improvement on February 26, 2003, as Employer contends. I give weight to Dr. McCallum's decision to release Claimant from orthopedic care because he performed the surgery on Claimant's knee and was familiar with his complaints and status after surgery. In addition, the medical records show no improvement in the knee after February 26, 2003, nor do they show that further treatment was contemplated after that time. Dr. Billington opined on October 6, 2003 that Claimant needs no further treatment for the knee injury of April 2002. On February 25, 2004, Dr. McCallum saw Claimant in follow-up and noted that his knee is stiff, he has not been in physical therapy, and he is still on narcotics. EX 18 at 488. However, he felt that Claimant is clinically stable and no orthopedic intervention

is necessary. Accordingly, I find that Claimant was temporarily disabled until February 25, 2003, and that his disability became permanent on February 26, 2003.

b. *Extent of Disability*

The question of extent of disability is an economic as well as medical concept. A claimant who shows that he is unable to return to his usual employment establishes a prima facie case of total disability. Even a minor physical impairment can establish total disability if it prevents the employee from performing his usual employment or the only employment for which he is qualified. *Elliot v. C & P Telephone Co*., 16 BRBS 89 (1984). A claimant's credible complaints of pain alone may be enough to meet this burden. *Anderson v. Todd Shipyards Corp.*, 22 BRBS 20 (1989). Once there has been a prima facie showing of total disability, the burden shifts to the employer to establish the existence of suitable alternative employment. *Bumble Bee Seafoods v. Director, OWCP*, 629 F.2d 1327, 1329 (9th Cir. 1980). Total disability becomes partial on the earliest date that alternative employment is established. *Stevens v. Director, OWCP*, 909 F.2d 1256, 1257 (9th Cir. 1990).

Claimant contends that he is totally disabled. With regard to Claimant's ability to return to work, Dr. McCallum opined on February 26, 2003, "I think at this point orthopedically he will not be able to return to the prior occupation he was at . . . and we have written work restrictions indefinitely." CX 17 at 32. When asked whether Claimant is able to return to his former occupation as a boat captain, Dr. McCallum testified, "it's whether or not they can, versus whether or not they should. So I don't know if he's able to do it, and I think his doctors treating him for the [RSD] would best be –answer to that [*sic*]. I don't think he should be doing it, as--as long as he's in the pain he has, and certainly as long as he's on pain pills."[7] CX 81 at 40. I note that Claimant returned to maritime employment as a mate on board a supply vessel from July 28, 2003 until September 19, 2003. Claimant testified that his left leg bothered him while at sea. He testified that since that time, he has not returned to work on boats because "there's too much pain in weather, any kind of weather or rocking, just trying to hold myself up." Tr. at 68-69. I find that the opinion and testimony of Dr. McCallum, together with Claimant's testimony about the knee pain he experienced at sea, is sufficient to establish that Claimant is unable to return to his usual employment. Accordingly, I find that Claimant has established a prima facie case that he is totally disabled. The burden shifts to Employer to establish suitable alternative employment.

To establish suitable alternative employment, an employer must show specific, realistically available jobs within the geographical area where the claimant resides, which he is capable of performing considering his verbal and technical skills, age, education, work experience, and physical restrictions, and which he could secure if he diligently tried. *Hairston v. Todd Shipyards Corp*., 849 F.2d 1194, 1196 (9th Cir. 1988). For the job opportunities to be realistic, the employer must establish their precise nature, terms, and availability. *Thompson v. Lockheed Shipbuilding & Constr. Co.*, 21 BRBS 94, 97 (1988). An administrative law judge may rely on the testimony of vocational counselors that specific job openings exist to establish the existence of suitable jobs. *Turney v. Bethlehem Steel Corporation*, 17 BRBS 232 (1985). However, positions identified by the vocational counselor do not constitute suitable alternate

[7] It is noteworthy that Dr. McCallum does not say that Claimant is disabled from his former occupation by the knee problems, but by the presumed RSD.

employment when there is doubt as to whether the employee could perform the jobs due to his education and physical restrictions. *Uglesich v. Stevedoring Servs. of America*, 24 BRBS 180 (1991). A failure to prove suitable alternative employment results in a finding of total disability. *Manigault v. Stevens Shipping Co.*, 22 BRBS 332 (1989). The employer may demonstrate that suitable alternate employment was available retroactively, so long as it overcomes "the inherent limitations of credible and trustworthy evidence." *Stevens v. Director, OWCP*, 909 F.2d 1256, 1260 (9th Cir. 1990).

Employer contends that Claimant is capable of returning to his pre-injury employment or performing alternative sedentary employment. Employer relies on a June 21, 2004 vocational assessment and labor market study performed by Carol Jacobsen, a rehabilitation specialist.[8] Ms. Jacobsen interviewed Claimant and reviewed his medical records as well as the results of his vocational testing and the FCE conducted by Ms. Arsenault in November 2003.[9] Ms. Jacobsen contacted Ms. Arsenault to clarify the FCE results and adopted her recommendation that Claimant pursue employment at the sedentary to light level, with lifting restrictions in the light category, and that with physical therapy and work-hardening, he might be able to perform medium work.[10] Tr. at 139. Ms. Jacobsen concluded that Claimant is employable, and she identified specific job openings in the light, sedentary, and medium categories that she felt would be suitable for him. Tr. at 141. These jobs included ship pilot, ship pilot dispatcher, truck driver, retail salesperson, and several general and specialty clerk positions. Pay scales range from $416.00 per week for retail salespersons to $760.00 per week for truck drivers. EX 15. Ms. Jacobsen submitted the jobs to Dr. Billington, who approved each job as consistent with Claimant's orthopedic limitations.[11] EX 15 at 107.

Claimant contends, based on the testimony and vocational evaluation report of vocational rehabilitation counselor Judy Weglinski, that he is permanently and totally disabled.[12] CX 78. Ms. Weglinski reviewed Claimant's medical records, employment history and FCE results, and conducted vocational testing. She concluded based on the FCE that Claimant is limited to sedentary work. CX 80 at 13. She testified that she observed Claimant was able to concentrate for only about three hours of testing due to reported pain. CX 80 at 15-16. Ms. Weglinski concluded "based on the severity and the chronic progressive nature of [his RSD]" that Claimant would not succeed in a rehabilitation plan. She felt he "could not reasonably be expected to

[8] Ms. Jacobsen has a Bachelor of Science in nursing (1981) and a degree in physiological psychology (1984), both from University of Alaska. EX 40. She is a registered nurse and certified rehabilitation registered nurse. Tr. at 184.

[9] Ms. Jacobsen testified that she reviewed the vocational report and utilized the vocational assessment, aptitude and interest profile compiled by Claimant's vocational expert, Judy Weglinski. Tr. at 137.

[10] Ms. Jacobsen testified that sedentary work requires lifting of less than 10 pounds, light work is lifting of 10 to 20 pounds, and medium work is lifting of 15 to 20 pounds. Tr. at 140.

[11] Dr. Billington approved the truck driver positions "on the basis of the findings on physical exam, i.e. objective findings not subjective complaints." EX 15 at 107.

[12] Ms. Weglinski has a Bachelor of Arts in psychology (1974) from Kutztown State University and a Master of Science in clinical psychology (1977) from Millersville State University, both in Pennsylvania. She is a Certified Insurance Rehabilitation Specialist (1988) and a Certified Vocational Evaluator (1984). CX 79.

satisfactorily tolerate full time attendance at any type of training classes and subsequent full time work." CX 78 at 270. She concluded that Claimant is permanently, totally disabled.

The fact-finder is to determine the claimant's restrictions based on the medical evidence and decide whether the claimant is capable of performing the jobs identified by the employer. *Villasenor v. Marine Maintenance Indus.,* 17 BRBS 99 (1985). For the reasons explained above, I reject Employer's contention that Claimant is capable of returning to his previous occupation as a ship pilot. Consequently, I find that the ship pilot positions presented by Employer do not constitute suitable employment. I also reject the positions identified in the medium category of work. Although Ms. Arsenault expressed the hope that Claimant might be able to perform medium work with physical therapy and work-hardening, the evidence does not show those steps have been taken. Accordingly, it cannot be said that medium work is currently within Claimant's physical abilities. *See Hayes v. P&M Crane Co.*, 23 BRBS 389 (1990), *vacated on other grounds*, 24 BRBS 116 (5th Cir. 1991) (determination of extent of claimant's disability is based on his vocational abilities at time of hearing).

Ms. Arsenault, Ms. Jacobsen and Ms. Weglinski agree that Claimant's FCE demonstrates that he is capable of performing sedentary work, although Ms. Weglinski felt he would be limited to part-time work at best. Dr. Billington approved the jobs identified by Ms. Jacobsen, including the full-time sedentary jobs, as within Claimant's physical capabilities. The record contains no contrary medical opinion regarding Claimant's ability to perform these jobs. Accordingly, I find that Claimant is physically capable of performing sedentary work. Ms. Arsenault and Ms. Jacobsen further opined that Claimant can perform light work with lifting restrictions. However, neither Ms. Jacobsen's report nor her testimony address the willingness of potential light-duty employers to accommodate Claimant's lifting restrictions. Therefore, I find that the light jobs identified by Ms. Jacobsen are not suitable, as there is doubt as to whether Claimant could perform them. *Uglesich v. Stevedoring Servs. of America*, 24 BRBS 180 (1991) (positions identified by vocational counselor are not suitable alternate employment when there is doubt as to whether the employee could perform the jobs due to his physical restrictions).

Ms. Jacobsen identified several jobs in the sedentary category which she feels are suitable given Claimant's work history, skills and aptitudes. First, she identified an opening for a ship pilot dispatcher which at a minimum requires experience as a ship pilot, although office experience with knowledge of computers is appreciated. The employer had one current opening and another anticipated in the "very near future." EX 15 at 155. Secondly, Ms. Jacobsen identified several specific sedentary clerical job openings. These included member services representative at a credit union, night auditor/front desk clerk at a local inn, hotel reservationist, and office manager at realtor's office. Each of these jobs requires a high school diploma or GED and good communication skills. Some also require use of telephones and some computer knowledge. Wages for a dispatcher range from $15.00 to $20.00 per hour, and clerks earn from $10.49 to $15.18 per hour. EX 15. Ms. Jacobsen testified that the jobs identified in the labor market survey of June 8, 2004 were available as of February 26, 2003, when Claimant reached maximum medical improvement. Tr. at 147-148. I find that his testimony constitutes credible evidence that the jobs presented were available at that time. *See Stevens v. Director, OWCP*, 909 F.2d 1256, 1260 (9th Cir. 1990).

Claimant is a relatively young man with a GED and substantial marine experience as a ship pilot and mate. Ms. Jacobsen testified that he is "very articulate," clean and presents well. Tr. at 185. Although Claimant has only limited knowledge of personal computers and lacks previous office experience, Ms. Weglinski reported that he "followed verbal directions well and caught on to new tasks easily. He was able to quickly understand computer administered tests easily despite his limited knowledge of personal computer use." CX 78 at 265. Ms. Weglinski's observations lead to the conclusion that Claimant is capable of acquiring on the job the computer skills required for unskilled or semi-skilled office positions, including ship pilot dispatcher and clerk. Ms. Weglinski also felt that Claimant was "professional, pleasant, and polite in his interactions" with her, and that he displays mature social and interpersonal skills in person and on the telephone. CX 78 at 266-267. This tends to show that Claimant has basic communication skills. Having considered Claimant's age, education, verbal and technical skills, work history, and physical restrictions, I find that Employer has shown a range of sedentary jobs which were available to Claimant as of February 26, 2003, and which he could secure had he diligently tried.

To the extent that Ms. Weglinski testified that Claimant does not have the computer skills necessary for a clerk job, I find her testimony inconsistent with her positive observations of Claimant's abilities to learn new tasks quickly. *See* Supplement to CX 80 at 13-14 ("CX 80 Supp."). Furthermore, the persuasiveness of her testimony is undermined by her incomplete command of the crucial facts. Ms. Weglinski mistakenly thought that Claimant does not have a GED, an important fact in the job market. *See* CX 80 Supp. at 13, 23. Finally, I am not persuaded by Ms. Weglinski's opinion that Claimant is unable to tolerate a full workday. She testified that her opinion is based on Dr. Shannon's diagnosis of RSD, Claimant's use of narcotic medications, and her observation that he had "an extraordinary amount of pain just doing vocational testing, which is considered light duty, sedentary type of work." CX 80 Supp. at 17. Having previously found that the medical evidence fails to establish that Claimant has RSD, I reject Ms.Weglinski's opinion to the extent that it is premised on "the severity and the chronic progressive nature of [Claimant's RSD]." Moreover, I am not convinced that pain precludes Claimant from working. I note that Claimant was unable to complete the second day of testing during the FCE and that objective evidence of increased heart rate corroborated his statements of discomfort. However, Ms. Jacobsen testified that she took this into account in concluding that Claimant's abilities put him in the sedentary, rather than light, category of work. Ms. Arsenault also reached this conclusion. For these reasons, I do not credit Ms. Weglinski's opinion that Claimant is unemployable.

In light of the foregoing, I find that the ship pilot dispatcher job and the range of clerical positions identified by Employer constitute suitable alternative employment for Claimant. Nevertheless, Claimant may establish total disability if he demonstrates that he diligently tried and was unable to secure employment. *Williams v. Halter Marine Serv.*, 19 BRBS 248 (1987). If an employee does not prove such, his disability is partial, not total. When asked whether he had looked for work, Claimant testified that he has "made phone calls," but did not know how many calls he had placed or whom he had called. Tr. at 93. He testified he has not reviewed Ms. Jacobsen's report because he was not given a copy, although he requested one. Finally, he testified that he has not applied for any sedentary jobs. Tr. at 94. The record contains no other evidence as to Claimant job-seeking efforts. I find that Claimant's testimony is insufficient to

establish that he diligently pursued, but has been unable to obtain, suitable employment. Accordingly, I find that Claimant's disability is partial, not total.

c. *Calculation of Scheduled Disability Benefits*

If an injury occurs to a body part specified in the statutory schedule, then the injured employee is limited to the schedule of payment contained in sections 8(c)(1) through (20) unless he shows total disability. *See Potomac Electric Power Co. v. Director, OWCP*, 449 U.S. 268 (1980). Under section 8(c)(2), an employee who suffers the permanent partial loss of use of a leg is entitled to that portion of 288 weeks of compensation which is equal to the percentage of lost use, even absent proof of an actual loss of wage earning capacity. *Nash v. Strachan Shipping Co*., 15 BRBS 386 (1983). Where, as here, an injured employee is found to be partially, not totally, disabled, the amount of benefits is limited to the amount in the schedule and may not be increased to reflect other losses, such as pain and suffering. *Young v. Todd Shipyards Corp.*, 17 BRBS 201 (1985). Pain may be relevant, however, in determining the extent of loss of use of a body part. *See Amato v. Pittson Stevedoring Corp.,* 6 BRBS 537 (1977).

In this case, two medical providers, Dr. Shannon and Dr. Billington, have given opinions concerning the extent of Claimant's loss of use of his left leg. Both opinions are purportedly based on the fifth edition of the AMA *Guides*. Dr. McCallum testified that he is not familiar with the *Guides* and does not do impairment ratings. Though I have rejected Dr. Shannon's opinion on the presence of RSD, I consider his impairment rating testimony because Alaska law allows chiropractors to provide disability and physical impairment ratings. *See* Alaska Statutes §08.20.100(b)(7) (2004). Dr. Shannon rated five distinct aspects of Claimant's condition. He assigned two-percent whole person impairment for saphenous nerve dysfunction, fifteen-percent whole person impairment for RSD, one-percent whole person impairment for the partial meniscectomy, four-percent whole person impairment for loss of range of motion in the knee, and two-percent whole person impairment for intractable pain. He combined the impairments to arrive at a 23-percent impairment of the whole person. CX 83 at 24-27. Dr. Billington opined that Claimant has a two-percent impairment of function of the left lower extremity as a result of the partial meniscectomy. EX 12 at 53. He testified that under the *Guides*, he has discretion to find additional impairment based on parameters other than the meniscectomy. He further testified that he typically would find additional impairment based on subjective complaints when the complaints are consistent with objective abnormalities documented on examination. EX 39 at 35. In this case, Dr. Billington concluded that there is no basis for additional impairment.

In evaluating the foregoing opinions concerning the extent of Claimant's left leg impairment, I find Dr. Billington's opinion to be more convincing. Among other reasons, I am more persuaded by Dr. Billington's views because he is a medical doctor and a board-certified orthopedic surgeon, while Dr. Shannon is a chiropractor. Secondly, having previously found that Claimant has not established that he has RSD as a result of his work injury, I reject Dr. Shannon's fifteen-percent impairment for RSD and agree with Dr. Billington that no rating for that condition is appropriate. A third consideration which leads me to conclude that any additional rating is inappropriate is Dr. Billington's report that Claimant exhibited a "considerable amount of non-physiologic behavior" on physical examination. EX 39 at 28. Dr.

Billington felt, in light of this behavior, that accurate assessment of Claimant's true left knee function could not be accomplished. EX 12 at 52.

One of the non-physiologic findings documented by Dr. Billington is "stocking hypesthesia," or decreased sensibility to superficial touch, in the entire lower left extremity. Dr. Billington testified there is no physiologic basis for this finding because an impairment of a nerve root or peripheral nerve would affect only a certain portion of the extremity. EX 39 at 29-30. He therefore felt it could not be accurately ascertained whether there is impairment of saphenous nerve function.[13] EX 12 at 53. Dr. Billington also felt that Claimant put forth "significantly less effort" on motor examination on the left than on the right. EX 12 at 50. He felt manual muscle testing was not objective since he noted Claimant's reduced effort on this part of the exam. For this reason, Dr. Billington concluded there was a lack of objective evidence of loss of strength in the extremity. He emphasized that there is "no atrophy present on which to accurately document muscle wasting," and no pitting edema from disuse that would result in inaccurate measurement. EX 12 at 53. He opined that Claimant, having experienced his symptoms for about a year and a half, would have appreciable atrophy of both thigh and leg if he were not using the limb. Finally, Dr. Billington testified that loss of range of motion could not be objectively relied on because it varied during the exam. He reported that Claimant said he was unable to extend the left knee beyond 30 degrees of flexion, but it was observed during other parts of the exam that Claimant stood with the left knee very slightly flexed or fully extended. *Id.* Dr. Billington concluded, based on the medical records and his examination and interview, that Claimant has a "profound disability syndrome, and that in an overall sense is probably much more important than any objective loss of function of the knee." *Id.*

I find that Dr. Billington presented a thorough explanation of the medical signs, or the absence thereof, which support his opinion that there is no objective basis for rating any impairment beyond the loss of function attributable to the partial meniscectomy. On the other hand, Dr. Shannon has given greater weight to Claimant's subjective complaints of pain in rating Claimant for saphenous nerve dysfunction, loss of range of motion, and pain. Because tests for range of motion and muscle function depend to a degree on the examinee's cooperation and are subject to his control, there is reason to question the accuracy of results which are not corroborated by objective medical evidence. This is especially true in a case such as this, where non-physiological findings provide reasons to question the credibility of the examinee. Dr. Billington's findings of non-physiological behaviors were consistent with those of Dr. Weiss. Dr. Weiss observed no atrophy and concluded Claimant "is really not limping or favoring that limb on a day-to-day basis." EX 38 at 12. She tested Claimant's strength and found he had "give-way" weakness of every muscle tested about the knee, ankle and toes on the left. She

[13] Dr. Weiss testified that her findings were not consistent with saphenous nerve abnormality. She rejected the electrodiagnostic study performed by Dr. Shannon. First, she felt Dr. Shannon's use of sensory evoked potentials to assess the saphenous nerve was improper, as he should use nerve conduction study. EX 38 at 24. Second, she felt Dr. Shannon should have "done quite a few more stimuli in each [trial]," and done more trials. EX 38 at 26. Dr. Weiss testified that the wave forms produced by Dr. Shannon's study were "not particularly reproducible," and she concluded the study was not adequate for interpretation. EX 38 at 26. Third, she opined that even if the data were adequate, the "normal" values evoked by Dr. Shannon were incorrect. She noted the acceptable range of normal differences between right and left extremities is up to 5.62 milliseconds. Because Dr. Shannon interpreted a right-left difference of 3.8 milliseconds as abnormal, Dr. Weiss felt the study is "nondiagnostic." EX 38 at 28. I find that Dr. Weiss's opinion supports Dr. Billington's decision to decline to rate impairment of saphenous nerve function.

testified that "give-way" weakness is a non-physiological finding and a sign of embellishment. *Id.* Dr. Weiss also reported inconsistent pain behaviors. She observed Claimant wince and complain of pain in response to light touch in the lower left abdominal area and down the left leg when he believed she was testing those areas; at other times, when she was checking other things, she observed no wincing or pain complaints when she touched those areas.

In light of the foregoing, I credit the opinion of Dr. Billington that Claimant's impairment is a two-percent impairment of the left lower extremity as a result of the partial meniscectomy. Claimant is therefore entitled to permanent partial disability compensation for two-percent of 288 weeks, or 5.76 weeks, pursuant to section 8(c)(2).

3. Average Weekly Wage

Section 10 sets forth three alternative methods for determining a claimant's average annual earnings, which are then divided by 52 pursuant to section 10(d) to arrive at an average weekly wage. These methods are directed towards establishing earning power at the time of injury. *Orkney v. General Dynamics Corp.*, 8 BRBS 543 (1978). Sections 10(a) and 10(b) apply to employment that is permanent and continuous, rather than seasonal and intermittent. *Duncanson-Harrelson Co. v. Director, OWCP*, 686 F.2d 1336, 1342 (9th Cir. 1982). Both 10(a) and 10(b) are premised on the injured employee having worked the entire year prior to the injury. *Id*. Average annual earnings must be computed pursuant to section 10(c) if sections (a) or (b) cannot be fairly applied. Here, Claimant began work for Employer on March 22, 2002, and worked through the first week of June 2002. The record is devoid of any detailed evidence of Claimant's actual earnings or hours worked prior to his job with Employer. However, Claimant testified that prior to his injury of April 5, 2002, he worked as a boat captain or mate on a seasonal basis, typically April through October. Tr. at 41. In light of this testimony, I find that Claimant did not work either as laborer or boat captain for the same or another employer during substantially the whole year prior to the injury. Section 10(a) is therefore not applicable. *See* 33 U.S.C. §910(a). Moreover, because Claimant's employment is seasonal and intermittent rather than permanent or continuous, I find that section 10(b) is not applicable. Accordingly, Claimant's average weekly wage must be determined under section 10(c).

A fact-finder has broad discretion in determining earning capacity under section 10(c). *Sproull v. Stevedoring Services of America*, 25 BRBS 100 (1991). The objective is to reach a fair approximation of a claimant's annual wage-earning capacity at the time of the injury. *Empire United Stevedores v. Gatlin*, 936 F.2d 819, 823, 25 BRBS 26 (5th Cir. 1991). Here, Claimant was injured while working as a laborer at the rate of $22 per hour preparing the *Bristol Endeavor* for voyage from Seattle to Alaska. CX 37. I find that this is not a reasonable reflection of Claimant's wage-earning capacity, however, because he was not engaged in his usual occupation of ship pilot. Once the vessel departed, Claimant earned $350 per day as master. CX 36. Claimant's federal income tax records show that he earned $25,179 in 2002, $45,140 in 2001, and $50,844 in 2000. EX 27. In 2002, Claimant began work for Employer in March, was injured in April, and worked through early June. I find it reasonable to assume that absent injury, Claimant would have had additional earnings from June 2002 until the season ended in October. For this reason, I conclude that Claimant's 2002 earnings do not fairly reflect his wage-earning capacity. Finally, I find that Claimant's earning pattern for the years 2000 and

2001 accurately reflects the amount he would have the potential and opportunity to earn absent injury. Accordingly, I find that a fair and reasonable average annual wage for Claimant is the average of his earnings for 2000 and 2001, or $47,992 (($45,140 + $50,844)/2 = $47,992). Under section 10(d), this sum is divided by 52 to arrive at an average weekly wage of $922 on the date of his injury, April 5, 2002.

4. Special Fund Relief

Section 8(f) shifts part of the liability for permanent disability from an employer to the Special Fund when the disability is not due solely to the injury which is the subject of the claim. The effect of section 8(f) is to limit the employer's liability to 104 weeks of compensation. Such relief cannot be awarded, however, if there is no award of permanent disability in excess of 104 weeks. *See Gupton v. Newport News Shipbuilding and Dry Dock Co.*, 33 BRBS 94 (1999). As explained herein, Claimant is entitled to 5.76 weeks of compensation, which is less than the 104 weeks required to invoke section 8(f). Accordingly, there is no basis for Special Fund relief.

5. Medical Expenses

Section 7(a) of the Act provides that "the employer shall furnish such medical, surgical, and other attendance or treatment . . . for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a). This provision has been interpreted to require an employer to pay all reasonable and necessary medical expenses arising from a workplace injury. *Dupre v. Cape Romaine Contractors, Inc.*, 23 BRBS 86 (1989). The employee must establish that the medical expenses are related to the compensable injury. *Pardee v. Army & Air Force Exchange Service*, 13 BRBS 1130 (1981). A claimant establishes a prima facie case when a qualified physician indicates that treatment is necessary for a work-related condition. *Romeike v. Kaiser Shipyards*, 22 BRBS 57, 60 (1989). In this case, Claimant contends he is entitled to reimbursement for unpaid medical bills and payment for future medical treatments, including palliative care, associated with the torn medial meniscus and RSD. He also contends that he is entitled to reimbursement for the cost of pain medicines to treat the symptoms of RSD.

The parties agree that Claimant's knee condition is causally-related to his April 5, 2002 accident at work. The evidence of record establishes that the meniscectomy performed by Dr. McCallum on July 16, 2002 constituted reasonable and necessary treatment for Claimant's knee injury. Accordingly, Employer is responsible for expenses related to the surgery and for any future medical treatment necessary for the residuals of Claimant's work-related knee injury. It is my conclusion that Claimant has not established that he developed RSD as a result of his knee injury, or even that he has RSD at all. Accordingly, I find that Claimant has not shown the compensability under section 7 of medical expenses associated solely with treatment for RSD.

6. Section 3(e) Credit

Section 3(e) provides a statutory credit for state workers' compensation benefits or Jones Act benefits received by employees. 33 U.S.C. § 903(e). The credit extends to compensation paid to the claimant, not to attorney's fees paid to his counsel. *See Lustig v. U.S. Dept. of Labor*, 881 F.2d 593, 22 BRBS 159 (9th Cir. 1989). Employer points out that Claimant received a sum of $15,000 for the settlement of his claim against Employer under the Jones Act, 46 U.S.C. §688, arising out of the same injury which is the subject of the present claim. Tr. at 25; EX 29. Employer is therefore entitled to a credit of $15,000, less any portion paid to Claimant's counsel, to be applied against the liability imposed herein.

7. Claimant's Motion to Supplement the Record

The Rules of Practice and Procedure for Administrative Hearings before the Office of Administrative Law Judges provide that the evidentiary record closes at the conclusion of the formal hearing unless the administrative law judge directs otherwise. *See* 29 C.F.R. §18.54(a). Once the record is closed, no additional evidence shall be accepted into the record unless it is shown that new and material evidence has become available which was not readily available prior to the closing of the record. 29 C.F.R. §18.54(c). Claimant's motion to supplement the record contains little beyond a bald assertion that his alleged RSD has "progressed and is spreading." Because Claimant has not shown that "new and material evidence has become available," his request to introduce additional evidence into the record is denied.

ORDER

It is hereby **ORDERED** that:

1. Employer shall pay Claimant compensation for temporary total disability for the period of April 5, 2002 to February 25, 2003, based on an average weekly wage of $922.

2. Beginning on February 26, 2003, Employer shall pay Claimant compensation for the permanent two-percent loss of use of his left knee pursuant to 33 U.S.C. §908(c), based on an average weekly wage of $922.

3. Employer shall pay interest on each unpaid installment of compensation at the rates prescribed under the provisions of 28 U.S.C. §1961.

4. Employer is not entitled to Special Fund relief.

5. Employer shall provide such future medical care as may be reasonable and necessary for the treatment of the injury to Claimant's left knee.

6. Employer is entitled to a credit under section 3(e) in the amount of $15,000.

7. The District Director shall make all calculations necessary to carry out this order.

8. Claimant's motion to supplement the record is **DENIED**.

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ALEXANDER KARST
Administrative Law Judge

AK:kb